

# Office of Health Facilities

## Application for Change of Information

Reference Guide for New Applicants

Let's begin!

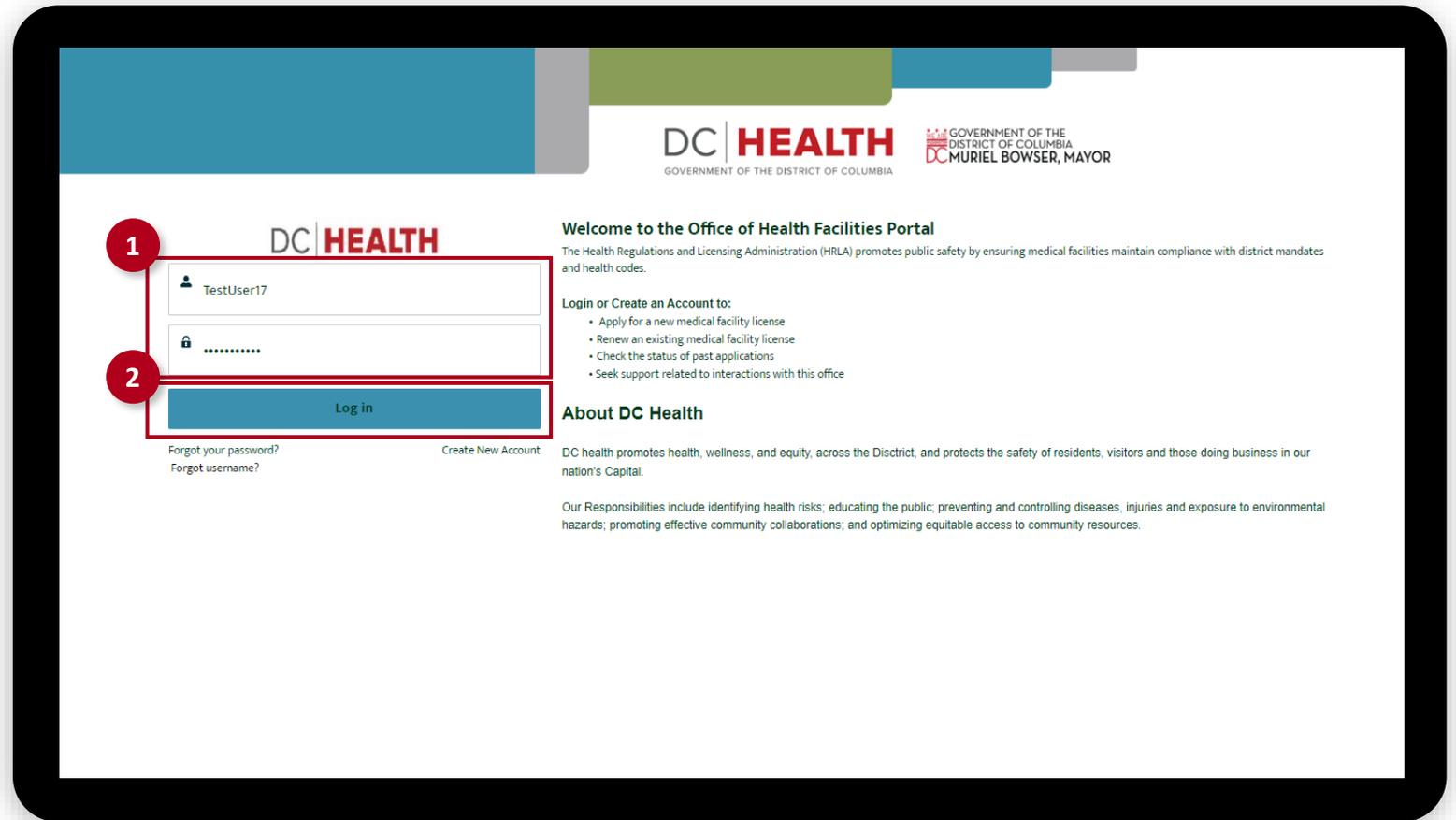
# Log In to the Platform

1 Enter your username and password.

2 Click the Log In button.

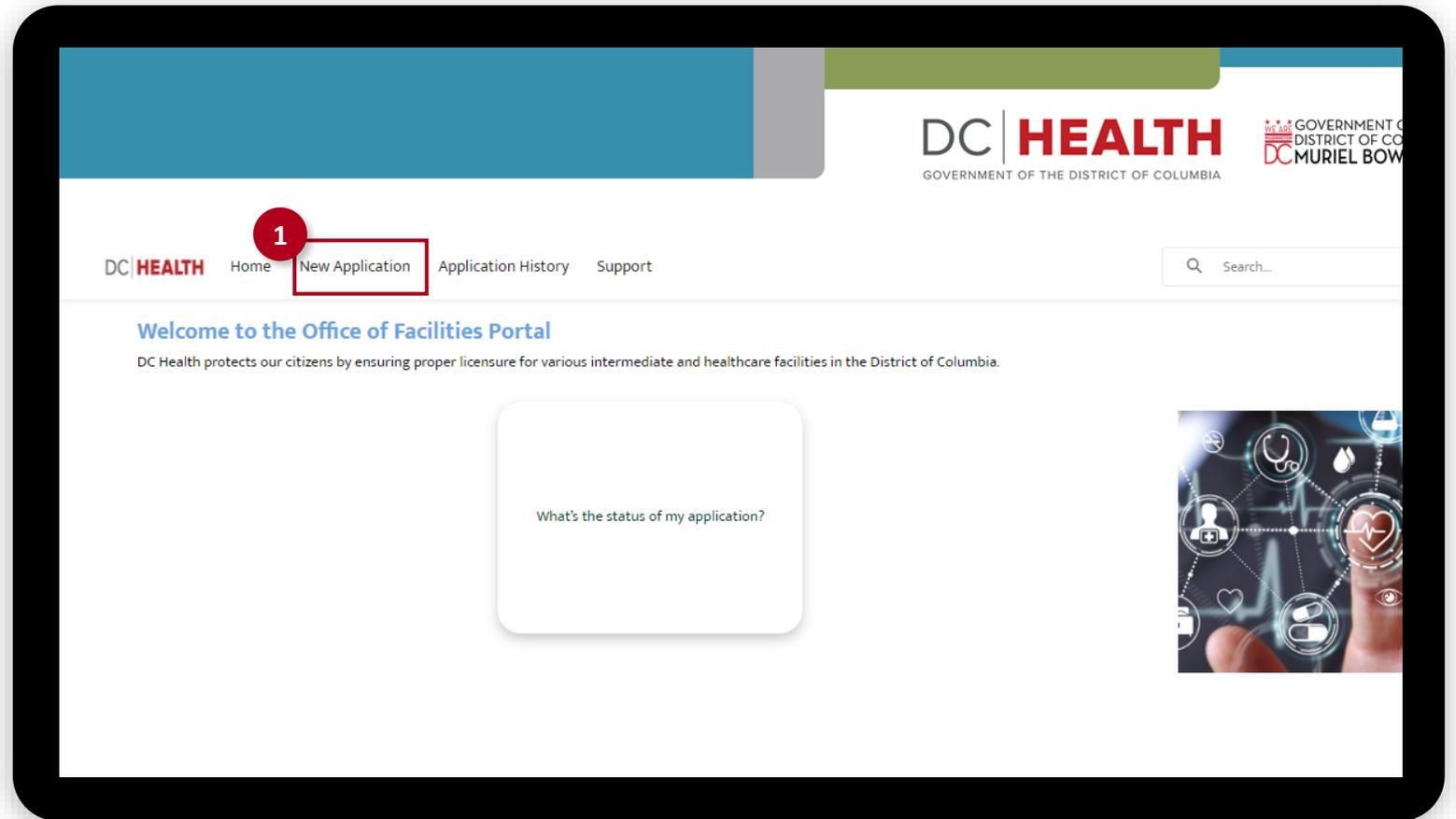


**TIP:** If you don't have an account click the **Create New Account** link.



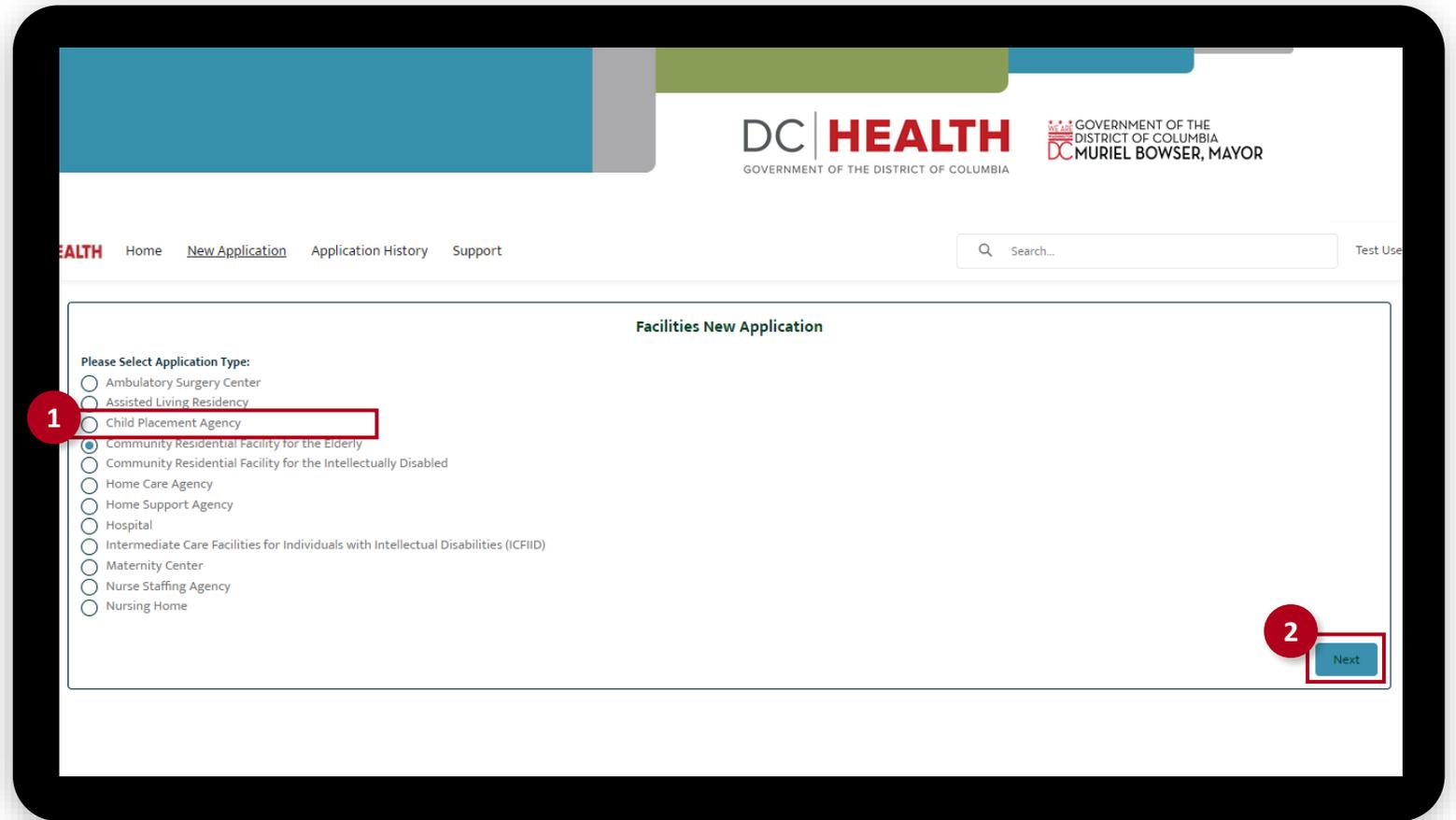
# Navigate to the New Application Screen

- 1 Once you Log in to the Office of Facilities Portal, click the **New Application** tab.



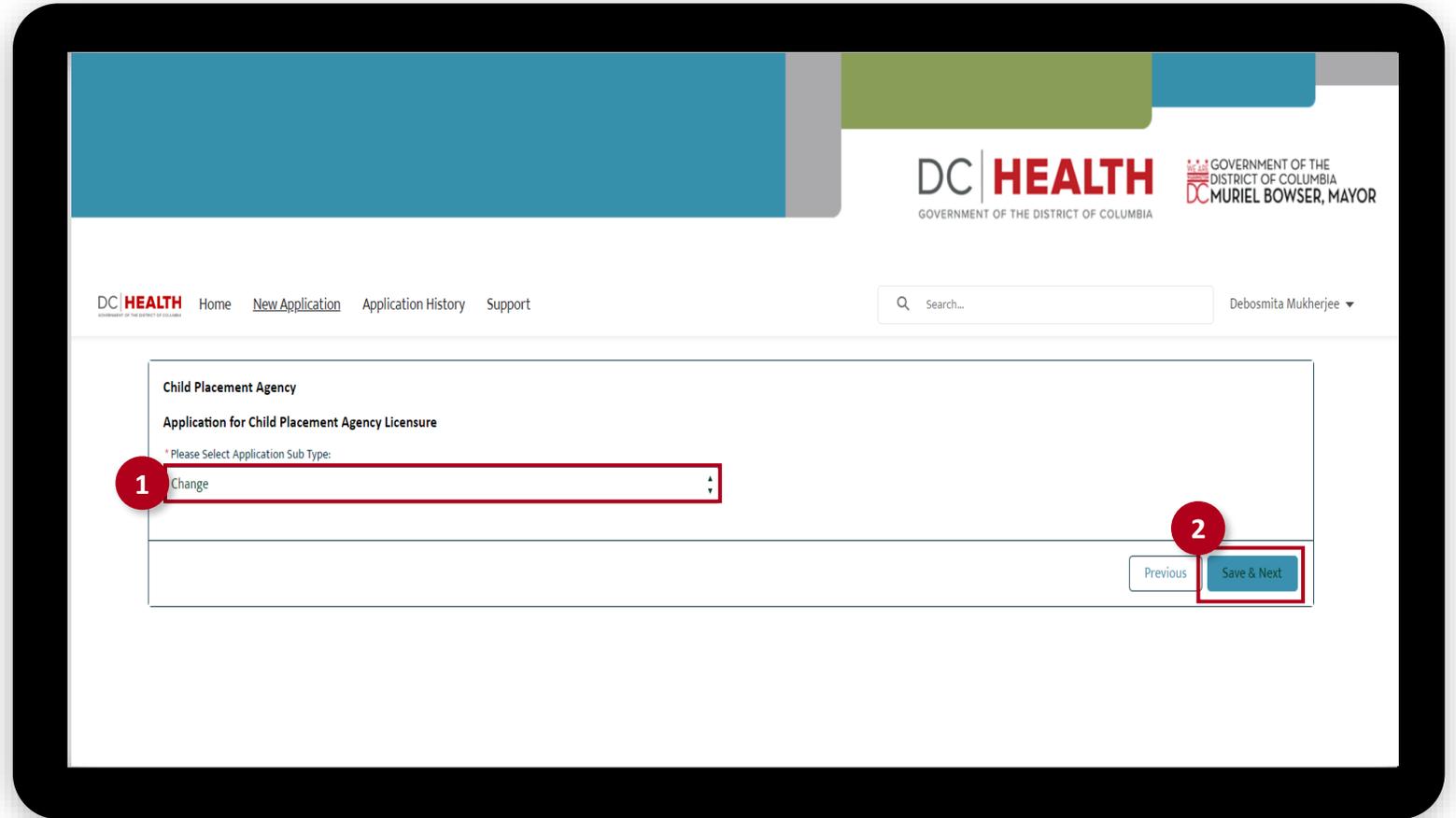
# Select the Application Type

- 1 Select the appropriate option from the list.
- 2 Click the **Next** button.



# Select the Application Sub Type

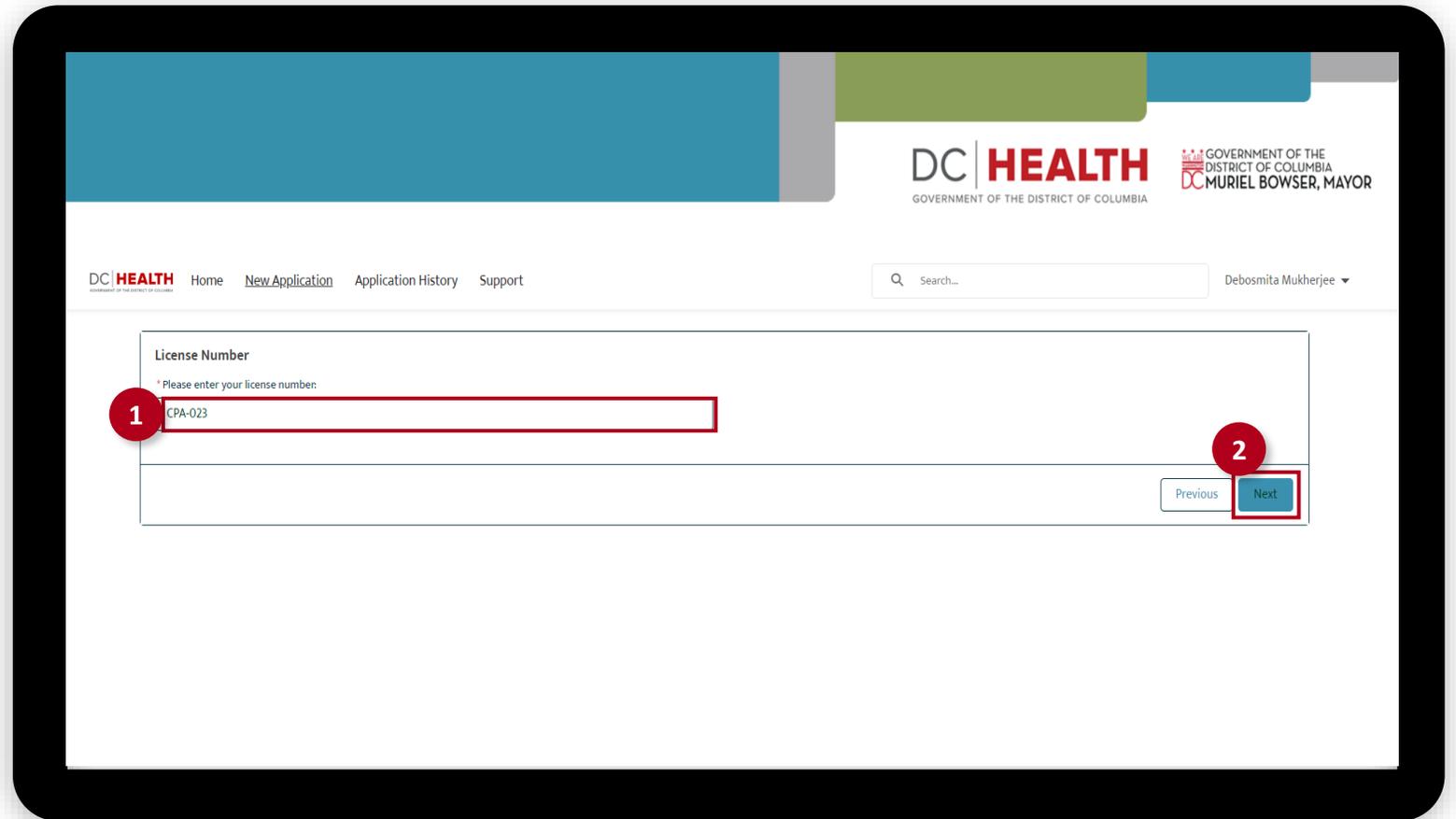
- 1 Select the **Change** option from the drop-down list.
- 2 Click the **Save & Next** button.



# Enter License Number

The licensee is the legal entity who has the ultimate responsibility and authority for the conduct of the facility.

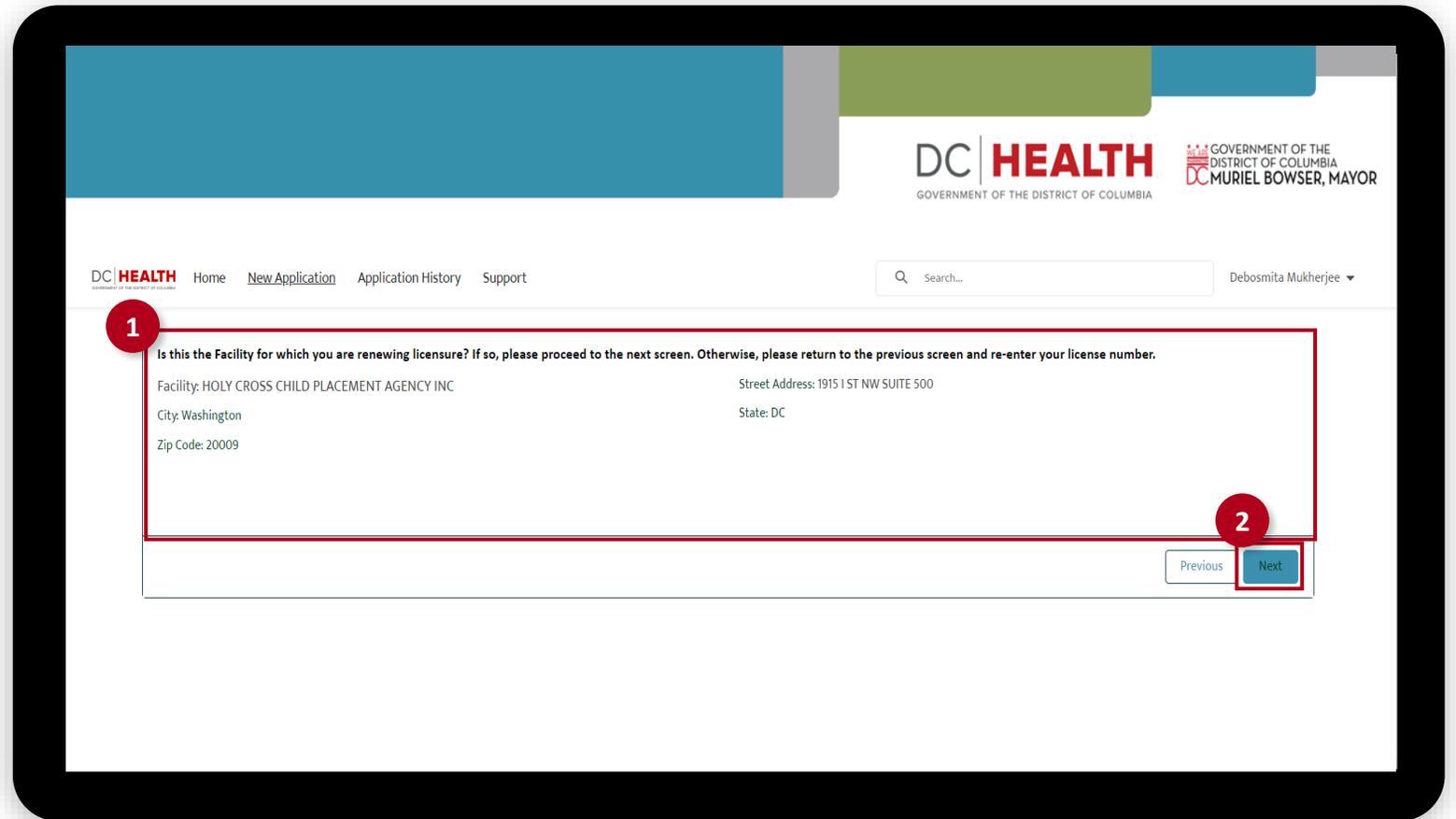
- 1 Enter your license number in the License Number field.
- 2 Click the Next button.



The fields marked with \* are mandatory and must be filled out to continue.

# Verify the License Information

- 1 Verify the details of the license.
- 2 Click the **Next** button.



The fields marked with \* are mandatory and must be filled out to continue.

# Select the Changes

- 1 Check mark **Change of Address** from the list.
- 2 Click the **Save & Next** button.

The screenshot shows the DC Health application interface. At the top right, there are navigation arrows. Below the header, the DC Health logo and the Mayor's name are visible. A navigation menu includes 'Home', 'New Application', 'Application History', and 'Support'. A search bar and a user profile dropdown are also present. The main form area is titled 'Change Type' and contains a mandatory question: '\*What change(s) would you like to submit? Please Select All That Apply:'. Three options are listed: 'Change of Address' (checked), 'Change of Name', and 'Change of Ownership'. A 'Previous' button and a 'Save & Next' button are at the bottom right of the form.



**TIP:** If you need to make multiple changes, check mark all that apply from the list.

*The fields marked with \* are mandatory and must be filled out to continue.*

# Fill in the New Address

- 1 Fill in relevant details under the new address section.
- 2 Click the Save & Next button.

**DC HEALTH** | GOVERNMENT OF THE DISTRICT OF COLUMBIA  
MURIEL BOWSER, MAYOR

Home [New Application](#) Application History Support

Search... Debosmita Mukherjee

**Address Change**

*FORMER address.*

Street Address: 1915 I ST NW SUITE 500 City: Washington  
State: DC Zip Code : 20009

*Please enter the NEW address.*

1

Street Address: 97704 Humberto Haven City: 3067 Jackson  
State: MS Zip Code: 30909-009

What is the anticipated date of relocation?  
Apr 4, 2023

2 Save & Next

# Fill in the Point of Contact Details

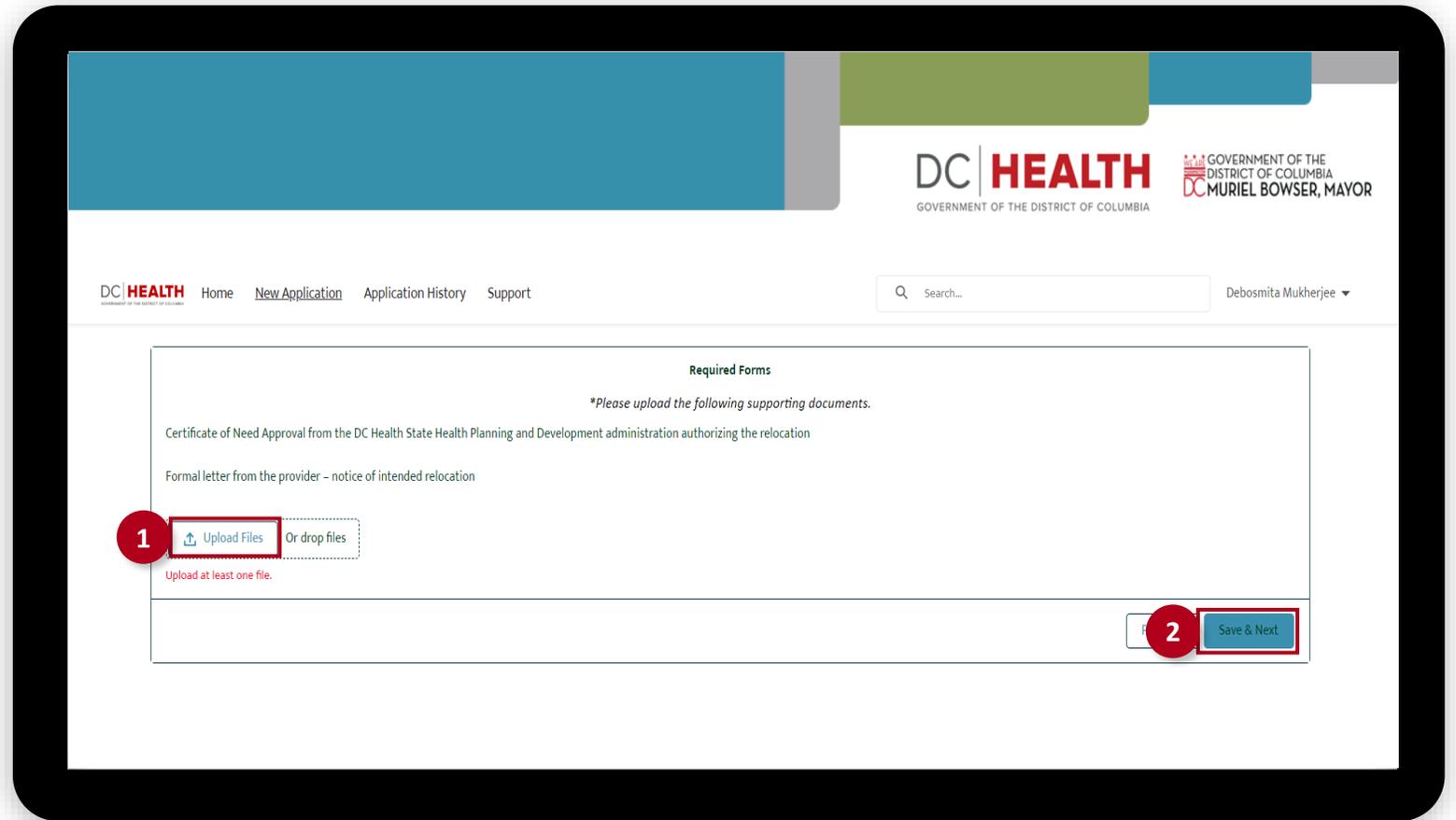
- 1 Fill in relevant details of the point of contact.
- 2 Click the Save & Next button.

The screenshot shows a web application interface for DC Health. At the top right, there is a navigation bar with the DC Health logo and the text "GOVERNMENT OF THE DISTRICT OF COLUMBIA" and "MURIEL BOWSER, MAYOR". Below this is a search bar and a user profile dropdown for "Debosmita Mukherjee". The main content area is titled "Point of Contact for this Application" and contains several input fields. A red circle with the number "1" highlights the entire form area. A second red circle with the number "2" highlights the "Save & Next" button at the bottom right of the form. The form fields are as follows:

* First Name	MI	* Last Name
Milan		O'Hara
* Title	* Address	
Product Response Producer	4G, 102 Lane, 4th Avenue	
* City	* State	
Aracelytown	NE	
* Zip Code	* Email	
47393	milamo'hara@fakedata.com	
* Mobile Telephone		
293-146-1079		

# Upload the Formal Letter

- 1 Upload the formal letter from the provider in pdf format only.
- 2 Click the Save & Next button.



# Verify the Fee Details

- 1 Verify the fee details.
- 2 Click the Save & Next button.



# Payment Selection

- 1 Verify the **Total Fee** of the transaction.
- 2 Click the **Next** button.



# Payment Wizard



1 Fill out the **Billing Address** and **Payment Info** fields.

2 Click the **Pay** button.

DC HEALTH Home [New Application](#) Application History Support

Sequi voluptas maiores nam. Test Users5

### Payment Wizard

Please complete the payment for your application using the form below. Click "Pay" when you are done inputting your payment details. If you are unable to pay at this time, you may exit this saved draft and return to it in the "Application History" tab of the portal header later.

After your payment has processed, click "Next" below to certify and submit the application. Your application will not be reviewed until these steps have been completed.

1

Billing Address	Payment Info
2879 Ortiz Crest	Solon Miller
788 Gottlieb Pass	3782 822463 10005
Fort Joan	09 / 25
Oregon	.... ?
16913-4451	

2 Pay \$390.00

Click the Next button at the bottom of this page to Certify & Submit the application.

Previous Next

# Fill out the Principals/Officers Information

- 1 Fill out all the required fields.
- 2 Click the **Save & Next** button.

HEALTH Home [New Application](#) Application History Support

Et sunt sunt dolor distinctio et facere maxime aut maxim Test Users

Name the principals/officers of the licensee: (such as, CEO, President, VP, Secretary, Treasurer, Director)

**1** Principal/Officer of the Licensee - 1

\* First Name Middle Name \* Last Name  
Brittany Lavinia Hudson Dibbert

\* Street Address \* City  
29299 Alva Shore Daniellastead

\* State \* Zip code  
AK 20001

\* Telephone Number \* Email  
172-865-5359 your.email+fakedata39187@gmail.com

\* Title  
Doctor

Add more Principal/Officers?

**2** Save & Next



**TIP:** If you need to add multiple Principals/Officers, select the **Add more Principal/Officers?** box.

The fields marked with \* are mandatory and must be filled out to continue.

# Fill out the Facility Staffing Information

1 Fill out all the required fields.

2 Click the Save & Next button.

The screenshot shows a web form titled "Facility Staffing" with a red border. A red circle with the number "1" is in the top-left corner of the form area. The form contains several sections and fields:

- Residence Director:**
  - \* Prefix: Mr. (dropdown)
  - \* Title: Legacy Mobility Executive
  - \* Name: Samir Maggio
  - \* Highest Level of Education Completed: Veum LLC
  - \* Name of Qualified Mental Retardation Professional (QMRP): Margarita O'Connell
- Other Professionals on Staff, if applicable:**
  - Director of Nursing:** Name: Tad Gusikowski
  - Primary Care Physician(s):** Name: Elouise Hoeger
  - Licensed Practical Nurse(s):** Name: Stanton Becker
  - Trained Medication Employee(s):** Name: Alexys Pfeffer
  - Live-In Staff:** Name: Jarvis Sipes

At the bottom right of the form, there is a "Save & Next" button highlighted with a red circle and the number "2".

The fields marked with \* are mandatory and must be filled out to continue.

# Fill out the Insurance Coverage Information

- 1 Fill out all the required fields.
- 2 Click the **Upload Files** button if needed to attach relevant documents.
- 3 Click the **Save & Next** button.

**Insurance Coverage**

Attach documentary evidence of financial responsibility on the part of the applicant as stipulated below

**1** Hazard (Fire and extended coverage) Minimum of \$500 per resident or \$2000 per facility

* Agency Name Onie Bergnaum	* Street Address 5538 Heidenreich Island
* City Jaquanton	* State NH
* Zip Code 20001	* Hazard Amount of Coverage 500

Liability Insurance - Minimum of \$300,000 per occurrence

* Agency Name Faustino Pfeffer	* Street Address 18877 Herminia Hill
* City New Dallasfield	* State SC
* Zip Code 20001	* Liability Amount of Coverage 300,000

\* Professional Liability (Explain)  
Consequuntur culpa sunt repudiandae neque repellendus aspernatur.

**2** Upload Files Or drop files

**3** Save & Next

The fields marked with \* are mandatory and must be filled out to continue.

# Payment Wizard



- 1 Once the Transaction is approved, click the **Next** button.

The screenshot shows the DC Health website's Payment Wizard. At the top, there is a navigation bar with 'DC HEALTH', 'Home', 'New Application', 'Application History', and 'Support'. A search bar contains the text 'Sequi voluptas maiores nam.' and the user is identified as 'Test Users5'. The main content area is titled 'Payment Wizard' and contains instructions: 'Please complete the payment for your application using the form below. Click "Pay" when you are done inputting your payment details. If you are unable to pay at this time, you may exit this saved draft and return to it in the "Application History" tab of the portal header later.' Below this, it states: 'After your payment has processed, click "Next" below to certify and submit the application. Your application will not be reviewed until these steps have been completed.' A large modal window is centered on the screen, featuring a green checkmark icon and the text 'Transaction approved'. In the background, a form is visible with fields for 'Billing' (2879 Ortiz Crest, 788 Gottlieb Pass, Fort Joan, Oregon, 16913-4451) and 'Info'. A 'Pay \$390.00' button is located at the bottom right of the form. At the bottom of the wizard, there are 'Pay' and 'Next' buttons. A red circle with the number '1' highlights the 'Next' button, and a red line points to it from the instruction text below the modal.

Click the Next button at the bottom of this page to Certify & Submit the application.

# Certify and Submit

1 Fill out the **Name** and **Date** fields.

2 Click the **Submit** button.



**TIP:** The date should correspond to the date you fill out and complete this form.

**HEALTH** Home [New Application](#) Application History Support

Soluta a animi magni quo aliquid voluptatem. Test User

### Certify and Submit

By clicking the submit button below, you are acknowledging that you are providing information for an official record and that the information you are supplying is true. By submitting this information, you understand that knowingly and willfully making a false statement on an official record may result in action against your license, registration, or certification and criminal penalties\*. This information will be held confidential by the Department of Health.

\*(a) A person commits the offense of making false statements if that person willfully makes a false statement that is in fact material, in writing, directly or indirectly, to any instrumentality of the District of Columbia government, under circumstances in which the statement could reasonably be expected to be relied upon as true; provided, that the writing indicates that the making of a false statement is punishable by criminal penalties or if that person makes an affirmation by signing an entity filing or other document under Title 29 of the District of Columbia Official Code, knowing that the facts stated in the filing are not true in any material respect or if that person makes an affirmation by signing a declaration under § 1-1061.13, knowing that the facts stated in the filing are not true in any material respect;

(b) Any person convicted of making false statements shall be fined not more than the amount set forth in § 22-3571.01 or imprisoned for not more than 180 days, or both. A violation of this section shall be prosecuted by the Attorney General for the District of Columbia or one of the Attorney General's assistants.

By electronically entering my name on this form, I attest that all statements are true and accurate.

\*Name  
Waylon Hyatt

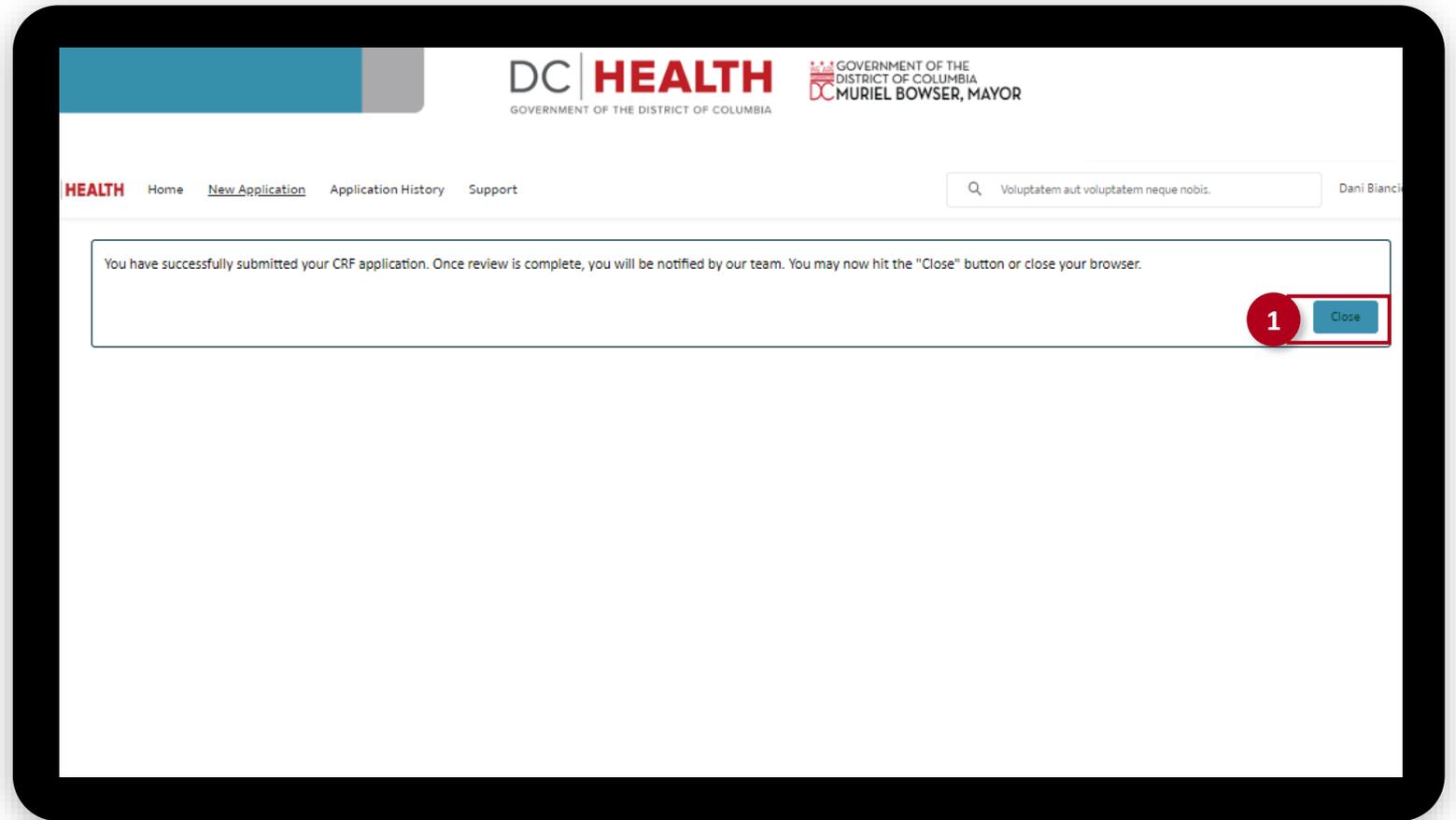
\*Date  
Oct 4, 2022

Submit

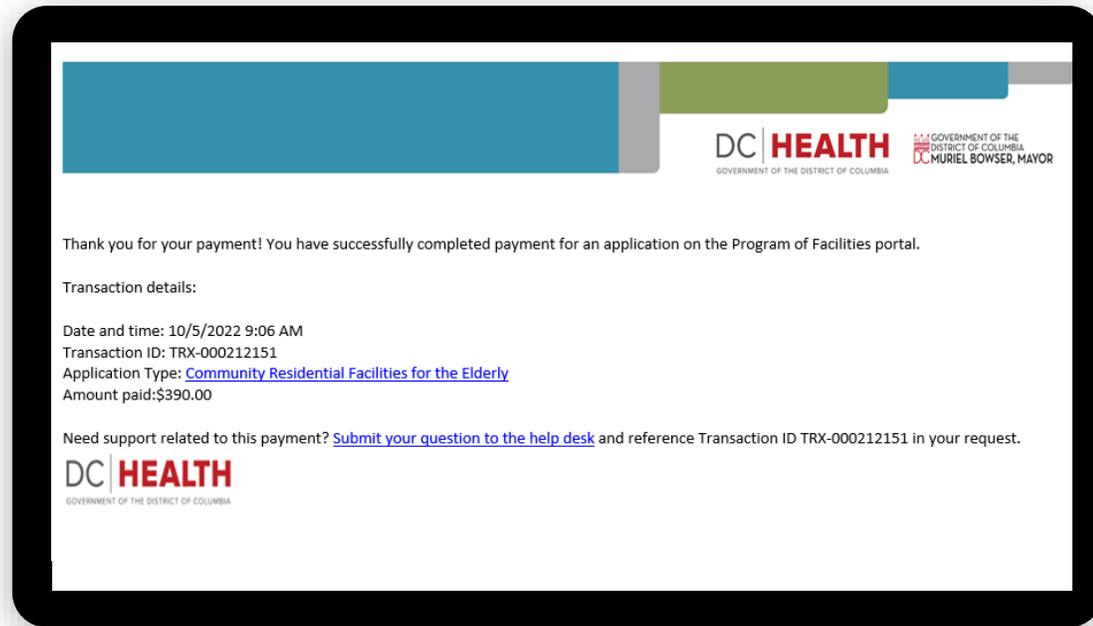
*The fields marked with \* are mandatory and must be filled out to continue.*

# Close the Application

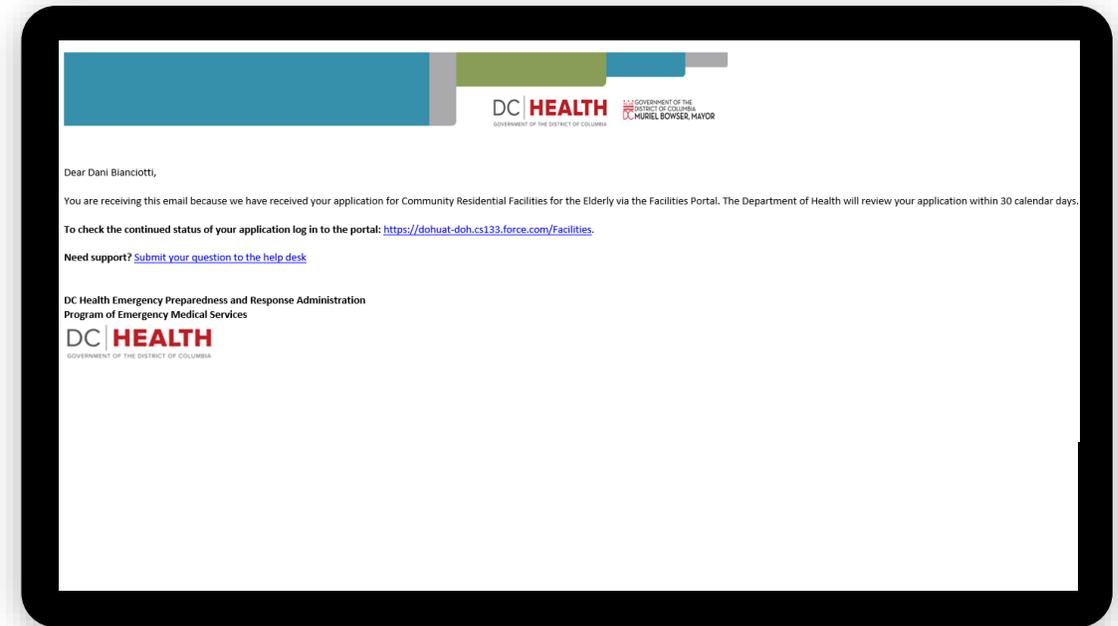
- 1 You have finished submitting your application. Click the **Close** button.



# E-mail Confirmation



**1** Check if you have received confirmation of payment.



**2** Check if you have received confirmation for your application.

# Thank you!